

## Test Script # 4 - Summary

This scenario involves a routine visit for a 77-year-old Veteran with multiple chronic problems including schizophrenia, dementia, poorly-controlled diabetes, hypertension, and drug allergies. Data from this case is used for a quality improvement initiative.

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## Key Features of this scenario are:

- . Disease Management
- . Drug/Drug Interaction
- . Drug Allergy
- . Electronic Prescribing
- . Data Collection
- . Quality Improvement Reporting

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.01	Login as Dr. Butler.	Login successful			
4.02	Look up patient record by last name SMITH. Select record for Theodore Smith.	<ul> <li>2 patient records found.</li> <li>Joe Smith</li> <li>Theodore S. Smith</li> <li>Patient record for Theodore S. Smith is selected.</li> </ul>		□ Pass	□ Fail
4.03	Check patient's medical eligibility; this should read "patient is eligible for coverage through 12/31/2007."	System displays medical eligibility obtained from patient's insurance carrier. This can be accomplished by a text note following telephone verification.		☐ Pass	□ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.04	Note that patient has a letter from his son that is causing him stress. Scan document into EHR.	EHR reflects the presence scanned document, and document is saved as a scanned image.		☐ Pass	□ Fail
4.06	Indicate that the Dr. Butler is the primary clinician for this patient.	Patient record identifies the Dr. Butler as the principal care provider.		☐ Pass	☐ Fail
4.07	Review health maintenance services for this patient.	System indicates that lab work is due.		☐ Pass	☐ Fail
4.08	Lipid Test: • Patient does not want the cholesterol test. Override the prompt and enter reason "patient preference."	System provides the ability to document the reason.		□ Pass	□ Fail
4.11	Review patient's allergies	Allergies display: • Penicillin • Sulfa drugs		☐ Pass	☐ Fail
4.12	Problem list displays:     Schizophrenia     Dementia     Positive for type 2     diabetes, elevated     cholesterol, hypertension,     Tobacco abuse is added to     problem list along with     appropriate coding.     System records user ID     and date of this update to     the problem list.     Resolved problems include:     appendicitis, cholecystitis     and a cataract.	Problem list displays:  Positive for type 2 diabetes, elevated cholesterol, hypertension  Tobacco abuse is added to problem list along with appropriate coding.  System records user ID and date of this update to the problem list.  Resolved problems include:  appendicitis, cholecystitis and a cataract.		□ Pass	□ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.13	Show active problems.	Problem list displays: • Schizophrenia, Dementia, Positive for type 2 diabetes, elevated cholesterol, hypertension and, tobacco abuse		□ Pass	□ Fail
4.14	Show inactive / resolved problems. (Note: does not require that the system display a list of inactive/ resolved problems only.)	Problem list (inactive/resolved) displays, indicating he has had: • depression • anxiety		□ Pass	□ Fail
4.15	Display cholesterol lab results (total cholesterol, LDL and HDL) graphically.	Graph displays with distinct data points by date and event. Graph should include four data points as entered from appendix and one from lab result received today.		□ Pass	□ Fail
4.16	Display lab results for LDL for this patient sorted by test date.	LDL results display as per Appendix C, sorted by test date.		☐ Pass	□ Fail
4.17	Display all lab results for this patient sorted by type of test.	Results display as per Appendix C, sorted by type of test.		☐ Pass	□ Fail
4.18	Change the interval for lipid testing to semi-annually for this patient.	The care plan for this patient can be modified.		☐ Pass	☐ Fail
4.19	In the Problem List, denote "hypertension' as "chronic".	System provides the ability to record the chronicity of the problem.		☐ Pass	□ Fail
4.22	View active medication profile.	All active medications display:  • Lipitor 20 mg a day  • Zantac 150 mg a day  • Risperidone 30 mg once daily  • Aripiprazole 12 mg a day  • Lisinopril 10 mg a day  • Tums 750 mg several times a day		□ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.23	Show how system provides the ability to create provider specific medication lists.	Applicant demonstrates this function. It is acceptable to either show a look-up using physician preferences or creating a new saved list.		□ Pass	□ Fail
4.24	Conduct follow up actions related to problem list: Schizophrenia – • Find notes for this patient with associated diagnosis Schizophrenia	Notes from at least two previous visits (as entered from appendix information) are available. *** DID NOT find specifie req for this.		□ Pass	□ Fail
4.25	Increase risperidone to 45 mg p.o. once daily #90 refill x 3	Prescription renewal is allowed. Dose is changed. Prescription is associated with problem Schizophrenia		☐ Pass	□ Fail
4.26	Create prescription for "schizophrenia wonder drug."	System allows entry of uncoded medication. System alerts that no interaction checking will be performed against the uncoded medication.		□ Pass	□ Fail
4.27	Associate medication respiridone and medication "Schizophrenia wonder drug" with problem "Schizophrenia"	System allows association of medication with problem.		□ Pass	□ Fail
4.28	Print risperidone prescription	"Schizophrenia" appears on the printed prescription as associated problem or diagnosis.		☐ Pass	☐ Fail
4.29	Refer patient to Schizophrenia Groups: Generate summary that includes problem list, medication list, allergies and adverse reactions. View and print summary.	Summary generated that includes:  • Problem list  • Medication list  • Allergies list.  Summary is displayed and then printed.		□ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.33	Delerium – • Renew Aripiprazole	System checks for drug-drug and drug- allergy interactions. Interaction with Risperidone displays.		☐ Pass	□ Fail
4.34	Override the alert. Document reason for overriding the drug-drug interaction warning as "combination taken previously."	System accepts reason.		□ Pass	☐ Fail
4.35	Set the severity level at which this drug interaction warning is displayed.	Severity level can be set.		☐ Pass	□ Fail
4.36	Proceed with renewal of Aripiprazole	Prescription is renewed.		☐ Pass	☐ Fail
	View active medication profile	All active medications display:  • Lipitor 20 mg a day  • Zantac 150 mg a day  • Aripiprazole 12 mg a day – renewed today  • St. Johns Wort  • Saw palmetto  • Lisinopril 10 mg a day  • Tums 750 mg several times a day  • Diabetes wonder drug  Aleve does not display.		□ Pass	□ Fail
4.38		System allows the note to be saved in progress prior to finalizing the note.		☐ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.42	Review patient's medication history profile.	All medications display (active and inactive):  • Lipitor 20 mg a day  • Zantac 150 mg tablet a day  • Risperidone 45 mg p.o. once daily #90 refill x3 – renewed today  • Aripiprazole 12 mg a day – renewed today  • Saw palmetto  • St. Johns Wort  • Lisinopril 10 mg a day  • Tums 750 mg several times a day  • Diabetes wonder drug		□ Pass	□ Fail
4.43	Review problem list	Problem list displays:  • Positive for type 2 diabetes, elevated cholesterol, hypertension and tobacco abuse (with appropriate coding) added today.  Resolved problems include:		□ Pass	□ Fail
4.44	Complete and sign off note. Print a copy for the patient.	Note is retrieved from "draft" status, updates to note are captured, and note accepts sign off. System captures identity of the user and date/time of finalization.		☐ Pass	□ Fail
	Logout as Dr. Butler.	Logout successful.			
	Login as Dr. Butler.	Login successful.		☐ Pass	☐ Fail
4.48	Select record for Theodore S. Smith.	Record selected.			
	Patient is to be referred to VA. Append the last progress note to document that the patient was referred to VA Logout as Dr. Butler	Note accepts the additional information. Identity of user who addended the note, along with date and time of change are recorded and displayed.  Logout successful.		□ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.60a (For Hybri d EHR/	Login as Dr. Butler. Select patient record for Theodore S. Smith.  Record history:  Create a prescription for Donepezil 5 mg by mouth twice daily for 7 days #14 2	Login successful. Patient record selected.  History updated with patient-provided information.  Note: When creating the prescription,	Actual Result	Pass  Pass	<b>⊳/Fail</b> □ Fail
		checking interactions, and reviewing medication lists, any of the following will disqualify a hybrid product as not having sufficient workflow integration:  • Evidence that the user has to log in a second time to a separate application.  • Evidence that the user must look up the patient again from a separate patient list.  • Evidence that the user must select the prescribed drug more than once, from separate lists.  • Evidence that the user must enter the patient's medications or allergies more than once, in separate lists.			

	Test Step	Expected Result	Actual Result	Pass	/Fail
(For Hybri d EHR/	Complete the prescription and send it electronically to the Test Pharmacy.  View patient's medication list in the EHR.  Setup Information: • Pharmacy Name: Test Pharmacy • NCPDP ID: 1112223 • Pharmacy Address: 233 N. Michigan Avenue Suite 2150 Chicago, IL 60601 • Prescriber Registered with Pre-Approved ePrescribing Network: Dr. Internist E. Butler, MD	Prescription is created and sent to the Test Pharmacy electronically. None of the disqualifying behaviors listed in 4.60a have occurred during steps 4.60a,		Pass	□ Fail
4.64	Display potential interactions relating to items on the medication list.	System displays potential interactions:  • Drug-allergy interaction between Donepezil and St. Johns Wort		☐ Pass	□ Fail
	Review encounter notes; filter, search or order by provider.	System provides the ability to filter, search or order notes by the provider who finalized the note. (Notes for this patient include visits with Dr. Butler and with Dr. Jones.)		□ Pass	□ Fail
	Display all encounters for this patient: • Filter by date of service; and • Filter by provider.	Encounters display, and are first filtered by date of service and then filtered by provider.		□ Pass	☐ Fail
	Logout as Dr. Butler.	Logout successful.			
4.68	Login as Office Manager.	Login successful.			

	Test Step	Expected Result	Actual Result	Pass	/Fail
	The physician is enrolled in a quality improvement initiative and has been collecting data for submission on the quality measures pertaining to schizophrenia Create a report that captures all patients with a diagnosis of schizophrenia including age and gender.  Note: Report may be created prior to the test.	Report displays, includes Jennifer Thompson and Theodore Smith. Report includes patient name, age and gender as requested.  Format of the output determined by the Applicant (e.g. printed report, HL7 message, delimited file, etc.).		□ Pass	□ Fail
4.70	Access patient record for Jennifer Thompson; mark this patient "exempt from reporting functions."	System provides ability to mark patient "exempt."		☐ Pass	□ Fail
4.71	Run report (as in step 4.69) again.	Report displays, includes Theodore Smith.		☐ Pass	☐ Fail
4.72	Create a hardcopy report for Joe Neighbour that shows:  The most recent visit; and All visits in the past two years.	Hardcopy output is created, for:  • The most recent visit; and  • All visits in the past two years.		□ Pass	□ Fail
	step 4.72, this time in electronic format.	An electronic file is created that can be read in Notepad (.txt, .rtf, .csv, etc) and shows:  The most recent visit; and All visits in the past three months.		☐ Pass	□ Fail
4.74	Show audit trail for the printing of the hardcopy output in step 4.72.	Audit trail shows date (today) and time (time of step above) and user (Office Manager) for print event.		☐ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.75	Create a report that captures all male patients.	Report displays, includes Theodore Smith, Joe Smith, Joe Neighbour, Will Haynes and David Carter.		☐ Pass	□ Fail
4.76	Create a report that captures all patients over the age of 20.	Report displays, includes Theodore Smith and Joe Smith. Jennifer Thompson does not appear as she is marked exempt from reporting functions in step 4.70.		□ Pass	□ Fail
	Save the report parameters from step 4.76.	System allows parameters to be saved.		☐ Pass	☐ Fail
4.78	Create a report that captures all patients on Risperidone	Report displays, includes Theodore Smith.		☐ Pass	☐ Fail
4.79	•	Report of patients over the age of 20 displays; includes Theodore Smith, Joe Smith; Jennifer Thompson does not appear as she is marked exempt from reporting functions in step 4.70. Patient identifier and address are removed for each patient.		□ Pass	□ Fail
4.80	Show audit trail of all users accessing Theodore Smith's chart on today's date.	Audit trail shows that this chart was accessed today by Dr. Butler and Dr. Alexander, including time of access for each user.		☐ Pass	☐ Fail

	Test Step	Expected Result	Actual Result	Pass	s/Fail
4.82	The Office Manager documents a disclosure made to a local health department as required by HIPAA.  • The date of the disclosure / report: 1/2/2007  • The name of the person making the disclosure: Dr. Alexander  • Reported to: Montgomery County Health Department  • Recipient's address: 2000 Dennis Avenue, Suite 238, Silver Spring MD 20902  • Information disclosed: — Patient's name — David Carter — Address — 1234 Willow Way, Silver Spring, MD 20902  — Phone: 301-555-4444  — date of birth: 3/2/2000  — diagnosis/condition: Rubella  • Purpose of the Disclosure: Required reporting for public health purposes	Applicant documents the following information to record the disclosure:  • The date of the disclosure;  • The name of the person making the disclosure;  • The name of the entity or person who received the protected health information;  • The address of such entity or person;  • The name of the person making the disclosure;  • A brief description of the information disclosed; and  • A brief statement of the purpose of the disclosure.  Free text (e.g. text note) or structured fields are sufficient to satisfy this requirement.		□ Pass	□ Fail
4.83	Logout as Office Manager.	Logout successful.			
4.84	Login as Dr. Alexander. Select patient record for Joe Smith (birthdate 3/23/1967).	Login successful. Patient record selected.			

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.85	Review medication list; the patient takes no medications.	System indicates that this patient currently takes no medications.		☐ Pass	□ Fail
4.86	Dispense a sample of Adderall. Lot number is F20457 and the expiration date is 11/2009.	System allows for identification of sample dispensed; lot number F20457 and expiration date 11/2009 display.		☐ Pass	□ Fail
4.87	Logout as Dr. Alexander.	Logout successful.			
	Functionality requires that	the EHR system supports multiple con	current users through application, OS	and databas	se. The
4.88	Login to the EHR system as Dr. Butler and access and view Theodore Smith's patient record.	Login successful.			
4.89	Keeping Dr. Butler's session active and open, login to the EHR System as Dr. Alexander and access and view Theodore Smith's patient record.	Login successful		□ Pass	□ Fail

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.90	NOTE:	The Applicant demonstrates that Dr. Butler and Dr. Alexander are able to simultaneously view the patient record for Theodore Smith.		□ Pass	□ Fail
	For instance, Applicant could demonstrate a networked EHR system and show how multiple users are able to simultaneously access the same patient record using different work stations. This would require additional set up by the Applicant to demonstrate this step.				

	Test Step	Expected Result	Actual Result	Pass	/Fail
4.91	Dr. Butler begins modifying an element (e.g., progress note, medication list, or blood pressure) in Theodore Smith's patient record. Before that entry is complete, Dr. Alexander concurrently accesses Theodore Smith's patient record and attempts to modify the chart. The system uses some mechanism (e.g. record-level locking, field-level locking, or other protection) to maintain the integrity of clinical data when multiple users access and attempt to modify the same element of the same patient record	Dr. Alexander is allowed to see the patient record, but is not permitted to modify the same element being modified by Dr. Butler. Either record-level locking (Dr. Alexander is blocked from making any changes to the record), field-level locking (Dr. Alexander is blocked from changing only the element being modified by Dr Butler), or another mechanism (e.g., Dr. Alexander or Dr Butler receive a warning of the conflict before they complete their entry) are acceptable.		□ Pass	□ Fail
4.92	With both sessions open, demonstrate that the users can view the same clinical documentation:  • Dr. Butler accesses and views clinical documentation in Theodore Smith's patient record; and  • Dr. Alexander accesses and views clinical documentation in the same patient record.	The Applicant demonstrates that Dr. Butler and Dr. Alexander are able to simultaneously view the same clinical documentation.		□ Pass	□ Fail

Test Step	Expected Result	Actual Result	Pass/Fail	
4.93 Logout Dr. Butler.	Logout successful.			
4.94 Logout Dr. Alexander.	Logout successful.			